Blue Options SM Benefits Highlights (PPO)

Physician Office Services *(See "Outpatient Clinic Services" for "outpatient clinic" or "hospital-based" services.)*	In-network	Out-of-network
Office Visits *Includes Office Surgery, Consultation, X-rays and Lab, and a benefit Period maximum of 4 office visits for the assessment of obesity in and out of network. See "Inpatient and Outpatient Services".*		
Primary Care Provider	$15 co-payment	70% after deductible
Specialist	$30 co-payment	70% after deductible
Preventive Care *Routine Examinations, Well-Child Care, Immunizations, Pap Smears, Mammograms, Prostate SPECIFIC antigen Tests (PSAs)*		
Primary Care Provider	$15 co-payment	Not Available*
Specialist	$30 co-payment	Not Available*
Therapies *Short-term Rehabilitative Therapies (Maximums apply to Home, Office and Outpatient Settings):* *Physical/Occupational: 30 visits per Benefit Period* *Speech Therapy: 30 visits per Benefit Period*		
Primary Care Provider	$15 co-payment	70% after deductible
Specialist	$30 co-payment	70% after deductible
Urgent Care Centers and Emergency Room		
Urgent Care Centers	$30 co-payment	$30 co-payment
Emergency Room Visit *(Inpatient Hospital benefits apply if admitted. If held for observation out patient benefits apply. See "Inpatient and Outpatient Hospital Services".)*	$150 co-payment	$150 co-payment
Ambulatory Surgical Center	90% after deductible	70% after deductible
Inpatient and Outpatient Hospital Services		
Hospital and Hospital Based Services	90% after deductible	70% after deductible
Outpatient Clinic Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
Hospital and Professional		
Outpatient Labs and Mammograms with surgery or other services.	90% after deductible	70% after deductible
Outpatient Labs and Mammograms without surgery or other services.	100%	70% after deductible
Outpatient X-rays, ultrasounds, and other diagnostic test such as EEG's and EKG's	90% after deductible	70% after deductible
CT scans, MRI's, MRA's, and PET scans in any location, including Physician's office	90% after deductible	70% after deductible
Other Services		
Skilled Nursing Facility *(60 days per Benefit Period)*	90% after deductible	70% after deductible
Home Health Care, Ambulance, Durable Medical Equipment and Hospice	90% after deductible	70% after deductible
Maternity *Maternity Delivery includes Prenatal and Post-delivery care*		
Hospital Services *(Delivery)*	90% after deductible	70% after deductible
Professional Services *(Delivery)*	90% after deductible	70% after deductible
Transplants		
Hospital Services	90% after deductible	70% after deductible
Professional Services	90% after deductible	70% after deductible
Infertility and Sexual Dysfunction Services *Up to $5,000 per Lifetime*		
Primary Care Provider	$15 co-payment	70% after deductible
Specialist	$30 co-payment	70% after deductible
Hospital Services	90% after deductible	70% after deductible
Inpatient Outpatient Professional Services	90% after deductible	70% after deductible
Vision Care		
Comprehensive Eye Exam	$15 co-payment	Benefit Not Available

Blue Options SM Benefits Highlights (PPO)

Lifetime Maximum, Deductibles & Coinsurance Maximums	In-network	Out-of-network
The following deductibles and Coinsurance Maximums only apply to the services on the previous page:		
Lifetime Benefit Maximum	Unlimited	Unlimited
Deductibles		
Individual *(per Benefit Period)*	$500	$1,000
Family *(per Benefit Period)*	$1,500	$3,000
Coinsurance Maximum		
Individual *(per Benefit Period)*	$2,000	$4,000
Family *(per Benefit Period)*	$6,000	$12,000

Prescription Drugs

Up to 30 day supply. 31-60 day supply is two co-payments and 61-90 day supply Is three co-payments. Infertility Drugs up to $5,000 Lifetime Maximum. MAC B Pricing, Brand Penalty

Tier 1 *(Generic)*	$10 co-payment	Co-payment + charge over In-network allowed amount
Tier 2 *(Preferred Brand)*	$35 co-payment	Co-payment + charge over In-network allowed amount
Tier 3 *(Brand)*	$50 co-payment	Co-payment +charge over In-network allowed amount
Tier 4 (Specialty Drugs)		75% of cost of medications

Mental Health and Substance Abuse Services	Certified	Not-Certified
**Inpatient/Outpatient Certification is required. Call Magellan Behavioral Health at 1-800-359-2422.*		
Mental Health Services		
Office *(30 visits per Benefit Period)*	$30 co-payment	70% coinsurance
Inpatient/Outpatient *(30 Days per Benefit Period)*	90% Coinsurance	70% coinsurance
Substance Abuse Services		
Office Visit	$30 co-payment	70% coinsurance
Inpatient/Outpatient	90% Coinsurance	70% coinsurance
Benefit Period Maximum	$8,000	
Lifetime Maximum	$16,000	

BCBS Medical Prices July, 2006 – June, 2007

Employee Only: $0 (*per pay period*)
Employee/Spouse: $115.69 (*per pay period*)
Employee/1Child: $31.48 (*per pay period*)
Employee/Family: $263.52 (*per pay period*)

Guardian Dental Services

Diagnostic & Preventive Care	100%
Basic Restorative Care	80% after Dental deductible
Major Restorative Care	50% after Dental deductible
Individual Dental Deductible *(per Benefit Period*)	$25
Family Dental Deductible (*per Benefit Period*)	$75
Combined Benefit Period Maximum (*Includes Diagnostic and Preventive, Basic and Major Restorative Care*)	$1,000
Orthodontic Care	50%
Lifetime Orthodontic Maximum	$1,000

Guardian Dental Prices July, 2006 – June, 2007

Employee only: $0 (*per pay period*)
Employee/Spouse: $10.44 (*per pay period*)
Employee/Child(ren): $16.78 (*per pay period*)
Family: $27.23 (*per pay period*)

Employee dependents are subject to late entrant penalties if they enroll in the Guardian Dental Plan during the group enrollment period.

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage or co-payment amount because actual provider charges may not be used to determine the payment obligations for BCBSNC and its members.